



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TEXAS HEALTH DBA INJURY 1 OF DALLAS  
SUITE 1000  
9330 LBJ FREEWAY  
DALLAS TX 75243

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative**

Box Number 19

#### **MFDR Tracking Number**

M4-13-1668-01

#### **MFDR Date Received**

March 4, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The patient was referred by his treating physician, John Milani, MD for a Pre-Surgical Psychological Evaluation. The service was denied per EOB precertification/authorization/notification absent. CPT code 90801 does not require preauthorization per rule 134.600."

**Amount in Dispute:** \$1,250.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Our Fee Schedule team reviewed the issue and advised: 134.6 [sic] states: (p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program; Charges need to be prior authorized per the above. At this time, Coventry does not recommend additional payment."

**Response Submitted by:** Gallagher Bassett Services, Inc.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2012	90801 x 5 units	\$1,250.00	\$1,238.06

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 19 – (197) Precertification/authorization/notification absent.
- BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt request, submit a copy of this EOR or clear notation that a rec

### **Issues**

1. Did the disputed service require preauthorization pursuant to 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. Per 28 Texas Administrative Code §134.600 “(p) Non-emergency health care requiring preauthorization includes: c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program.”

The Medicare AMA CPT ® Code book defines CPT code 90801 as “Psychiatric diagnostic interview examination.”

The requestor states in their position summary that the disputed service is an Initial Behavioral Medicine Consultation ordered by the treating physician, John Milani, MD. 28 Texas Administrative Code §134.600(p) (7) requires preauthorization for repeat interviews, the requestor documents that CPT code 90801 is the initial interview. The insurance carrier did not submit documentation to support that this charge was a repeat interview. As a result, the disputed CPT code 90801 will be reviewed pursuant to 28 Texas Administrative Code §134.203.

2. Per 28 Texas Administrative Code §134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.”

The requestor seeks reimbursement in the amount of \$1,250.00, the MAR reimbursement for CPT code 90801 per unit is \$247.61 x 5 units equals a MAR amount of \$1,238.06, this amount is recommended.

Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT code 90801 x 5 units in the amount of \$1,238.06

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,238.06.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,238.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 9, 2013  
Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).